Author’s response to reviews

Title: Addressing harm in Moral Case Deliberation: the views and experiences of facilitators

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Dear editor,

We thank you for giving us the opportunity to improve the paper, taking advantage of the reviewers’ comments. We are very grateful for the constructive comments of the two reviewers. We revised our paper, following a substantive part of the suggestions. Below you will find both our detailed responses to the comments and a description of how and where we changed the original manuscript in order to improve the overall quality of the paper.

We have uploaded the revised manuscript with and without track changes. The page numbers mentioned in the response refer to the manuscript version including track changes.

On behalf of the other two authors, Guy Widdershoven and Hans Alma,

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Reviewer #1:

Reviewer reports:
Stella Reiter-Theil (Reviewer 1): General comments Addressing and reflecting harm, even tragedy, is in the eyes of the reviewer not only an important topic in activities such as MCD or Ethics Consultation (EC); it is a necessary component thereof. The topic's extension towards tragic situations is also appreciated as this is often not hidden behind pragmatic outcome oriented thinking.
Response: Thank you for your positive evaluation of the topic of our paper.

Thus, the topic of this paper appeared most promising motivating to the reviewer to accepting the task. However, reading the paper entirely took several efforts and it was not easy to carry on as the manuscript did not quite maintain the initial interest and curiosity. While this may be a rather subjective comment, there are also some more substantial aspects that may help to explain why the reading of the paper was not as rewarding as hoped. Response: Thank you very much for your critical and constructive review. We have explained the aim of our article more clearly. Identifying the harm in a moral dilemma is part of steps in the dilemma method. Little attention however is given to what the patient or the professional has to give up, when a course of action is chosen in a dilemma. The research question addressed in this paper is: How can MCD support healthcare professionals in tragic situations by addressing this harm? A sentence is added to make this more clear. (p.4)

Harm (and addressing it) in MCD can deal with harm that patients are experiencing in relation to their illness independently from the MCD process or with harm that staff involved is perceiving due to the burdens they have to face as part of the MCD process. As a motivation for this paper, a lack of studies on harm addressed in MCD is emphasized.

The same mentioned lack is surprising and contrasts the observation that the literature on Ethics Consultation is referring to harm as a topic of reflection in EC quite often. Frequently, but not always, this corresponds with referring to the 4 principles approach of Beauchamp and Childress including the non-maleficence principle. But even without acknowledging this theory, EC must not miss addressing harm on a regular base as even the routine reflection of treatment options covers the explicit weighing of benefits and burdens (harm). Response: These are important theoretical questions, which indeed require more attention. We have added the following lines on p. 4 to make this more clear: “In our concept of harm we follow Nussbaum. (Nussbaum 2000, Nussbaum 2001, p. 25). It concerns the moral damage that cannot be avoided or resolved. This differs from the four principles approach of Beauchamp and Childress including the non-maleficence principle ‘one ought not to inflict evil or harm’ (Beauchamp and Childress 1994, p. 190-193), often used in Ethics Consultation. In Ethics Consultation harm is a topic of reflection in weighing up beneficial and non-beneficial effects (Montaguti et al. 2019, Reiter-Theil et al. 2018). Doing so requires balancing the outcomes and choosing the best solution. (Beauchamp and Childress 1994, p. 291) Following Nussbaum, whatever option one chooses, a fundamental moral damage remains, which cannot be resolved, but needs to be acknowledged. That is the harm we address in this paper.”

Moreover, harm (in clinical encounters or ethics meetings) is not restricted to being a result of a patient's condition or situation; harm might also result from the options that are considered as candidates for problem solution: thus, reflecting beneficial and non-beneficial effects (harm) of decisions or options is one of the core functions of EC - and possibly also of MCD. Response: We agree that it is important to reflect on beneficial and non-beneficial effect during EC and MCD. Little attention however is given to what the professional has to give up, when a course of action is chosen in a dilemma. Our concern in this paper is harm in the latter sense, in terms of moral damage.

Additionally, harm could also mean that it is being experienced in relation to participating in an MCD. Response: Thank you for this remark. We have added this and mentioned this in the discussion. See p. 24.
Errors and mistakes have been studied in the EC literature contributing valuable insight in this aspect of harm within a consultation.

On many occasions it has been described that MCD is not (any more) a mainly educational tool, but also used as a practical approach of helping healthcare staff in addressing ethical problems in clinical situations - like Ethics Consultation. Still, the literature of the related fields is not acknowledged. It would have been interesting to read some thoughts about the question, why MCD has fallen short of addressing harm in its practice so far. Why is there no inclusion of the topic of errors and mistakes here?
Response: Thank you for this comment. In healthcare this is indeed a very important topic. We deliberately did not include the topic of errors and mistakes. It is outside the scope of our article, since we do not deal with (avoidable) errors but discuss harm as fundamental damage. We do not address avoidable damage, but moral harm which is inherent to making a decision in a tragic situation. We made this more clear in the background section, and have added a sentence in the discussion on p. 22, line 522.

Specific comments

Clear definitions of harm or tragedy are lacking; they should make the connection to the practical context of MCD visible.
Response: Thank you for this comment. The definition of harm is addressed on p. 3, line 69. We have given it more attention in adding extra lines on p. 4, line 89-93. For the definition of tragedy we follow Nussbaum (p. 5, line 120). To clarify this we have added a summarizing line on p.6, line 136.

The results section lacks structure and is less than clearly arranged. The quotes are too long and too many for the provided content distracting the reader's interest.
Response: Thank you for this remark. For the content analysis we used the Grounded Theory according Charmaz. According to Grounded Theory, substantial quotes are necessary to draw out the most important themes from the interviews. We have deleted some quotes and shortened the quotes when possible. (see results section)

Also the discussion section requires a more stringent structure. As clinical - "tragic" - situations or examples have been mentioned, it would have been convincing to come back to them elaborating on the findings in the discussion section. Rather, the interesting categories extracted from the interviews are presented in combination with comments that are, partly, not very insightful, especially with the first part (1. Awareness of tragedy), e.g.: "that discussing harm in MCD can help healthcare professionals to realise that there is no ideal solution" (p. 21, line 501 ff). More of the kind follow, e.g. on pages 23, 25, 26.
Response: Thank you for your remarks. We have changed the passage you mention, coming back to the examples mentioned in the beginning. See discussion section, page 22.

The second part (2. Dealing with tragedy) is better to read and richer in content. Additionally to the topics of harm and tragedy the authors refer to moral injury and moral distress - on the side of the healthcare professionals. As they aim to address "resilience" later, this choice makes sense. However, providing definitions and differentiations regarding these key concepts is necessary, but lacking.
Response: Thank you for this remark. We have added the definitions of the concepts of moral injury, moral distress and resilience in the discussion section.
The content of the conclusions does not really "follow" from the results.
Response: This is of course of main importance. During the total review of our article, we have studied the results again very carefully. We have sharpened the conclusion accordingly. (see conclusion)

Reviewer #2:

GENERAL COMMENTS: This paper is useful in analyzing health care providers' responses to tragedy (insoluble moral dilemmas at the edges of life in which either moral choice between alternatives is a bad one). Through interviews and content analysis involving coding, the authors find common themes from those interviews. The results provide significant insight into how health care providers handle tragedy at a practical level and reveal a level of compassion that transcends the bureaucratic maze of contemporary health care. This paper should definitely be published.

The authors provide an interesting paper concerning health care providers' experience of using "moral case deliberation" in dealing with "tragedy." "Tragedy" is when either moral choice made leads to negative consequences for the patient. They use a subset of "content analysis," Charmez' "Grounded Theory," to analyze data from the health care providers in order to find common themes in how they deal with tragedy. Coding is used to determine which themes are used most frequently by health care providers in this context. This is a well-known method in the social sciences to determine how many instances of a particular theme or opinion come up, in this case, through analyzing health care providers' comments during interviews with researchers. I am impressed with the care taken in this study; the quantization of qualitative responses drew out the most important themes from the interviews classified in terms of whether they were ways of awareness of tragedy and dealing with tragedy. The results are useful in helping understand an area not widely researched, since most research has dealt with patients' and families' reactions to tragedy and not to health care providers' reactions. Providers' responses indicate them to be compassionate to the point of sometimes narrowing the professional distance that is found in patient-provider relationships. This is a worthy, carefully planned study that should definitely be published.

Response: Thank you for your review and positive evaluation of our article.